

LYMAN (C.B.)

Omphalocele —
Umbilical Hemorrhage





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OMPHALORRHAGIA—UMBILICAL HEMORRHAGE.

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This is a subject which our writers on obstetrics have considerably slighted. In looking over a large number of standard authorities from 1840 down to the present time, I find that less than one-half of them make any mention at all of the subject; and many of those give it but a passing and casual notice.

Probably the first case reported was by Mr. Watts, of Kent, who in 1752 published its history in the Gentlemen's Gazette nearly a century then passed by before any further publications on this subject appeared.

Dr. Francis Minot, of Boston, in 1852, published, in the American Journal of Medical Sciences, the histories of 41 cases in the practice of himself and others; these cases occurred from the first to the thirteenth day after birth. In 1855 Stephen Smith read a monograph embodying the histories of 79 cases; in 1858 J. Foster Jenkins read a paper before the U. S. Medical Association, which was published in the transactions for that year, in which he gave the histories of 178 cases; of these 34.5 per cent. were females and 65.5 males; the hemorrhage started in from the first to the 56th day; the days were recorded in 99 of these cases as follows:

1st day, five cases; 2nd day, seven cases; 3rd day, six cases; 4th day, three cases; 5th to 7th day inclusive, thirty-two cases; 8th to 10th day inclusive, twenty-five cases; 11th to 15th day inclusive, sixteen cases; 16th to 21st day inclusive, four cases; 22nd to 56th day inclusive, one case.

In 1859 Grandidier reported 202 cases; in 135 of them the time of occurrence of hemorrhage was noted, in 38 it came on before the cord had separated, in 26 at the time of separation and in 71 after that



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time. From that time up to the present there have been frequent reports of cases. Jardin, in the British Medical Journal for March, 1891, reports a case of fatal hemorrhage on the 20th day; R. H. Montgomery in the New York Medical Journal for 1892, reports a case occurring on the eighth day, four days after separation of the cord, it recovered. Lugeol, in the Journal de Médecine de Bordeaux, for Nov. 22nd, 1891, says that in 4,000 deliveries in the Maternity of Bordeaux, he had seen but one case and considers it a very serious condition. Chas. Craig reports one case in the Medical News of Philadelphia for Nov. 24, 1894.

When hemorrhage occurs during the first three days of life, the source is, in all probability, from the walls of the umbilical fossa outside the line of attachment of the cord. The most common time for hemorrhage to take place is between the 5th and 15th day, namely, after the cord has fallen.

Symptoms: The first symptom which is noticed in most cases is the fact that the binder is saturated with blood, the hemorrhage does not come in spurts, but as a gentle oozing and is, therefore, very dangerous; it saturates the binder and clothes, and if it should chance to come on at night may become so great, before being discovered, that recovery is impossible. If the loss of blood has been considerable, we will have the usual symptoms which accompany severe hemorrhage; in very many cases we will have hemorrhage from other parts of the body, such as the mucous membrane of the nose, mouth, vagina, stomach and rectum.

Causes: Standing foremost in the list of causative agents is the condition of hæmophilia; in a very large proportion of cases this condition has been found to exist; it may or may not be an inherited condition; when this hemorrhagic diathesis is present other symptoms will usually accompany that of hemorrhage from the umbilicus, such as epistaxis, hæmatemesis, hæmaturia, and hemorrhage from the vagina, rectum and into the subcutaneous tissue. Next in importance as a causative agent comes inherited syphilis. Parvin reports a case where the child died in 24 hours from hemorrhage; the parents were syphilitic; they were placed on anti-syphilitic treatment and the

mother subsequently gave birth to four healthy children. Mracek, in 1886, reported 19 cases due to syphilis. J. G. Simpson, of Edinburgh, in an article on this subject, says that it is his opinion that in many of the cases the cause is to be found in a thickened condition of the vessel walls, which interferes with their contractile power, the infiltration being due to an inflammatory condition. Some cases seem to be due to a debilitated condition of the mother during the carrying period due to tuberculosis, cancer, etc.

Prognosis: The prognosis in these cases is decidedly bad; five out of every six die. When due to a distinct hemorrhagic diathesis or when accompanied by jaundice they seldom recover; the average duration of these cases is three and one-half days, according to Jenkins.

It has been my fortune to see two of these cases, brief histories of which I give:

CASE 1. This case I saw in 1887, the child, a male, was born apparently healthy, the parents were healthy; owing to their poverty there was no experienced nurse in attendance; the hemorrhage came on at the time the cord fell off, or rather at the time when the old woman in attendance pulled it off; the hemorrhage was quite severe. I reached the patient in two hours, when I found it almost bloodless; compression controlled the flow of blood, but the child died before anything further could be done.

CASE 2. Mrs. A., a primipara, gave birth to a female child weighing nine and three-quarter pounds. The cord separated and fell on the sixth day. On the thirteenth day I was called on account of oozing of blood, which had stained through the binder. I filled the umbilical fossa with liquor ferri subsulphatis, covered it with styptic cotton and applied pressure by means of a tight bandage. there was no further hemorrhage until the next day, when I was again called. At this time I found fresh and quite alarming hemorrhage, amounting to half an ounce. I removed all dressings, took a medium sized curved needle threaded with medium sized silk, stitched the umbilical fossa completely up, passing the thread from one side to the other and back, tying it securely, but not tight enough to cause

any danger of subsequent sloughing of the delicate tissues; in crossing the base of the fossa the stitches did not include any of the tissues at that point, but were passed just above the base. This completely controlled the hemorrhage; a dressing was then applied of aristol powder, a small pad of absorbent cotton saturated in flexible collodion was secured to the skin by the abundant use of collodion. This dressing was not disturbed for five days, when it was removed; the stitch was cut out and a simple dressing of aristol and cotton applied. It is now four weeks since the dressings were removed and there has been no return of the hemorrhage; the child is perfectly healthy in every respect.

In this case I feel that the cause of the hemorrhage was a lack of contractile power in the walls of the vessels, together with a lack of coagulative power in the blood. The parents were both perfectly healthy; showed no evidences of hæmophilia, syphilis or other constitutional disease. The interest in this case of course, centers in the treatment.

Burns, in his "System of Midwifery," published in 1843, recommends the use of astringents, nitrate of silver, the actual cautery, plastering over the umbilicus a solution of gutta percha, and digital pressure kept up, if need be, for days by frequent changes of nurses; as a last resort he suggests that one might make an incision upwards from the umbilicus and down to the peritoneum for the purpose of ligating the umbilical vein, and an incision downward from the umbilicus for the purpose of securing the arteries. In the literature at my command I find that the varieties of treatment are not extensive and consist first in the application of astringents and styptics such as alum, liquor ferri subsulphatis, styptic cotton, etc. Second comes the use of caustics, such as nitrate of silver and the actual cautery. Third, compression either by means of the finger or by means of pads properly applied and held in place by a bandage or by the application of such adhesive materials as a solution of gutta percha or flexible collodion, or pressure by plaster-of-Paris applied over the umbilicus and held there until dry. Lastly we come to what may be called operative measures, consisting in the first place of cutting down on the

arteries and vein and tying them, a procedure alike difficult and dangerous in the new-born child; next, the use of hare-lip pins is suggested, two of them being used and passed through the fossa at right angles to each other, just escaping its base, and then applying a ligature around them, either in a figure of eight or circular manner. Lastly I would suggest the method used in this particular case.

It is the universal opinion of all authorities that the application of astringents, styptics and caustics is of little avail and that compression is uncertain; my own idea is, that they are all uncertain and are dangerous to use. In this case reported, the result was due as much to the careful watching on the part of the nurse as to the efforts of the physician. Hereafter I shall not waste valuable time or run any risk by making use of applications or compression, but when first called shall make use of the suture, applied as it was in this case, which I consider as efficient and much safer than the method laid down in most of the text-books by the use of the hare-lip pin; there will not be the danger of sloughing from pressure; a suture can be left in longer than the pins and leaves no large holes; the dressing of absorbent cotton saturated in flexible collodion adds to the security of the method.

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